Progress through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION | JUNE, 1981 | ISSUE #4

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June)

MEDICAID MEDICARE EXCHANGE

CONNECTICUT MMIS SYSTEM

Electronic Data Systems, Inc. (EDS) is the successful bidder for an MMIS RFP issued in October by Connecticut's Department of Income Maintenance. EDS will upgrade, transfer and operate an MMIS, with full implementation by September 1981. A cost of approximately $13 million is expected for initial development and operations over a four year period. EDS has installed this type of system for Medicaid programs in Kansas, Missouri and North Dakota. The Connecticut MMIS will include:

- EPSDT notification, tracking and reporting capabilities. (EDS has proposed to utilize EPSDT programs developed and operated by EDS for the Tennessee Medicaid program.)

- Reporting capabilities to accommodate preparation of the HCFA-80, HCFA-120 and HCFA-2082 reports.

- Claims processing of the HCFA-1500 Common Claim Form for practitioners, the UB-16 form for hospital billing, ICD-9-CM diagnosis coding, and CPT-4 coding for medical and surgical procedures.

The system will also include unique Connecticut requirements for claims correction forms, spenddown processing, enhanced TPL processing, and increased financial capabilities. For further information, contact Gerry Merrigan, Region I, FTS 223-1467.

PROPOSED REPEAL OF CERTAIN MEDICARE AMENDMENTS

The Department of Health and Human Services is seeking repeal of several provisions of the Omnibus Reconciliation Act of 1980 (P.L. 96-499), enacted December 5. The Department believes these amendments would add significantly to the costs of the Medicare program. Among the provisions proposed for repeal are:

- Unlimited home health visits under Medicare Parts A and B, in addition to other minor home health benefits;

- Medicare coverage of inpatient alcoholism detoxification services;

- Medicare coverage of rehabilitative services in certain comprehensive outpatient rehabilitation facilities; and

- Medicare coverage of services performed by dentists which would be covered under the current law when provided by a physician.

Last year, Congress also decided to defer Medicare reimbursement for the last three weeks of FY 81 to hospitals using the Periodic Interim Payment (PIP) system of reimbursement. The

continued on page 2

EDITOR'S NOTE: SEVERE BUDGET RESTRICTIONS HAVE DELAYED M/MMI'S REGULAR PUBLICATION OF MMX #4. IN THE INTEREST OF RELEASING THIS ALREADY DELAYED ISSUE, M/MMI HAS PHOTOCOPIED MMX #4 AND DISTRIBUTED IT IN LIMITED SUPPLY. M/MMI WOULD APPRECIATE THE WILLINGNESS OF HCFA REGIONAL OFFICES, STATE AGENCIES AND CONTRACTORS TO PHOTOCOPY ISSUES OF MMX #4 REQUESTED BY REGULAR READERS WHO WILL NOT RECEIVE IT.

MEDICARE ENROLLMENT UNDER P.L. 96-499

HCFA's Bureau of Support Services (BSS) is implementing two provisions of the Omnibus Reconciliation Act of 1980 (P.L. 96-499) which abolish the General Enrollment Period and allow an unlimited number of enrollments. These provisions will affect the maintenance of the national Medicare master file.

General Enrollment Period: Under the previous legislation, a person who did not apply for Supplemental Medical Insurance (Part B) during the seven month initial enrollment period could apply for this insurance between January 1 and March 31 of a succeeding year. The initial enrollment period includes the month of the claimant's 65th birthday, the three preceding and three following months. A similar restriction also applies to enrollment in the Medicare Hospital Insurance (Part A) program by persons who would have to pay premiums of coverage because they are not entitled to a monthly social security benefit.

As of April 1, 1981, the Omnibus legislation allows persons to apply for either Part A or B at any time. Entitlement begins on the first day of the third month following the month of filing.

Reenrollment in Medicare: The previous law gives an individual only two enrollments in the Medical Insurance or premium Hospital Insurance program. Previously, any beneficiary whose entitlement terminated twice was barred by law from reenrollment, except through a State buy-in agreement.

The Omnibus Act removes this restriction. BSS is expanding its entitlement records to allow electronic access to each beneficiary's entire entitlement history.

Bob Flagg, 301-594-8390, FTS-934-8390, can answer questions about BSS implementation activities.

Proposed Repeal - continued from front page

intent of the deferment is to reduce Federal expense for FY 81 by $515 million; however, it adds $522 million to FY 82 costs, since hospitals using PIP can borrow money to meet cash flow needs during the deferral period. The money borrowed by the hospitals will cost the government approximately $7 million in interest.

The Department is also seeking repeal of a section of P.L. 96-911, which extends Medicare coverage of pneumococcal vaccine for the elderly. The Department has learned that this vaccine has not been shown to be effective in protecting the elderly against pneumonia. Contact: Richard Chambers, 202-426-3717.

SETTING THE RECORD STRAIGHT

In the article, "Early and Periodic Screening, Diagnosis and Treatment Subsystem Development," in January's Child Health Checkup section, California is described as the first State to incorporate an EPSDT subsystem within the guidelines of the MMIS General Systems Design (GSD). This statement is correct; however, there are other States that have EPSDT subsystems in their MMIS that meet HCFA guidelines. California is the first to implement an EPSDT subsystem using the draft GSD. The EPSDT GSD will be published in October 1981.

Editor

DR. PAUL R. WILLGING NAMED DEPUTY ADMINISTRATOR

Dr. Paul R. Willging became HCFA's Deputy Administrator on March 26. He had been acting in that capacity until Dr. Carolyne K. Davis, HCFA Administrator, selected him to be her deputy.

Prior to this assignment, Dr. Willging had been the Acting Director and Deputy Director of HCFA's Bureau of Program Operations. He was also Deputy Director of the Medicaid Bureau 1975-79, Associate Administrator for Planning, Evaluation and Legislation within the Health Services Administration 1973-75, and Director of HSA's Division of Health Evaluation 1971-73. His Federal career began in 1969 as a management intern with the Department of Health, Education and Welfare.

Dr. Willging holds M.S. and Ph.D. degrees in political science from Columbia University. He succeeds Earl Collier, who resigned January 30.

MIS CONFERENCE

HCFA sponsored a national conference, Management Information Systems (MIS) - Benefits to Management, in Kansas City, Missouri, June 2-4.

Among the numerous discussion topics were: HCFA's perspective on a "new beginning" for information systems; the Schweiker Amendment, P.L. 96-398; the MMIS systems performance review for FY 82; and the National Medicaid Quality Control Data Base and Network. Attendees were from DHHS/HCFA central and regional offices and other government agencies, State medical assistance programs, and private firms. These organizations are engaged in information systems data processing, software development and hardware manufacturing for health care financing and related applications.

For further information, contact Bea Smith, OMS Coordinator, 301-594-8441, FTS 934-8441; or Marlene Jones, M/MMI Coordinator, 301-594-8945, FTS 934-8945.

SPEECH PATHOLOGIST INDICTED

On December 12, 1980, Charles R. Turner, speech pathologist and owner/administrator of the Tyler Communications Disorders Center in Tyler, Texas, was sentenced to serve three years at a minimum security facility after entering a plea of guilty to one count of a thirty count indictment. Twenty-nine of the thirty counts were dismissed upon oral motion of the government following the guilty plea.

The total indictment included 12 counts of alleged false statements to Medicare, 9 counts of alleged false statements to the government, and 9 counts alleging forgery. Mr. Turner entered a guilty plea to knowingly and willfully making false statements and misrepresenting material facts with respect to meeting the requirements of Conditions of Participation for Medicare and Medicaid. Mr. Turner also listed names of persons holding certain positions with the center, knowing such persons did not hold such positions. This was also in violation of the Medicare law. For further information, contact Jo Batchelor or Mary Ace, FTS 729-6401.

Early and Periodic Screening, Diagnosis, and Treatment

NATIONAL EPSDT CONFERENCE

Some 125 persons from 40 States, and HCFA regional and central offices attended the national Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) conference in Denver, Colorado, March 17-19.

Yale University Professor Dr. George A. Silver, who has been involved in Medicaid's child health program for years, delivered the keynote speech. Dr. Silver set the tone for the conference by emphasizing the importance of interagency collaboration during the coming decade: "Under the circumstances, it behooves the State agencies that have common goals to huddle together, examine their budgetary requirements, and determine which programs can be consolidated, which ones can be administered jointly, which ones may safely be eliminated....now it's cooperate or perish."

Panels and moderators were: Developmental Assessment - Stephen Leeds, OCH; Promoting EPSDT - Bill Collins, Region X EPSDT Coordinator; Collaborative Services - Bill Hiscock, OCH; and Management and Information Systems - Stephen Leeds.

Kenneth Koppenhoefer, Deputy Director of BPO's Office of Standards and Performance Evaluation, advised the group that the EPSDT State assessment package will soon be ready for State comments, with implementation planned for October 1.

Other activities included workshops highlighting effective practices in four key EPSDT program areas: program design, outreach and informing, case management information systems, and screening, diagnosis and treatment.

For specific information regarding the conference, contact Pat Hotkowski, 301-597-1878, FTS 987-1878.

EPSDT AUDIOVISUAL - THE BODY SHOP

A State approved videotape, The Body Shop, is now being screened in public assistance offices in New Orleans. The Body Shop, created and produced by the New Orleans Video Access Center, a nonprofit organization, informs public assistance recipients about available EPSDT services. The State of Louisiana had the responsibility to review the script for accuracy and content.

Several graduate social work students recently interviewed recipients to determine the effectiveness of the film. Of those interviewed, 87 percent said they watched the film while waiting to be served, and 75 percent said they would request EPSDT services.

This videotape was presented by Dallas regional office staff to State and regional EPSDT coordinators at the Denver EPSDT conference in March. The Body Shop was also shown at the 13th Annual State Medicaid Directors' Conference in Philadelphia on April 13-15. Additional information about this audiovisual can be obtained from Betty Collins, Region VI, FTS 729-6481.

DISTRICT OF COLUMBIA AWARDS EPSDT CONTRACT

On November 7, 1980, the District of Columbia's Department of Human Services (DHS) selected Philadelphia Health Management Corporation (PHMC) to manage EPSDT services for that jurisdiction's Medicaid program. On February 7, 1981, the contractor began arranging screening for 25,000 children at $20.00 per screen. Total cost of the one year contract is $499,900.

This contract will expand and improve the availability of comprehensive health care services for the District's Medicaid recipients under 22 years of age. Services covered under the contract include: outreach activities, recruitment, (re)training, monitoring, and (re)certification of EPSDT providers, establishment and maintenance of an effective case management system, and development of a data processing system to handle the collection of data, invoice processing and Federal reporting requirements. The District's MMIS system, currently under development, could be interfaced with this data processing system.

Specifically, PHMC will:

- provide personnel to perform outreach activities,
- provide a training program to teach staff proper techniques of effective client outreach services,
- provide a client appointment system capable of handling a large volume of appointments and rescheduling of appointments not kept,
- promote EPSDT awareness in the community,
- certify and enroll EPSDT providers,
- design and implement a system capable of tracking clients from the time of eligibility determination through informing, initial screening, followup for diagnosis or treatment, and the rescheduling of appointments,
- perform invoice processing and issue reports, and
- submit client's request for transportation to EPSDT coordinator.

The District's Medicaid agency, the Office of Health Care Financing (OHCF), is establishing a tracking system to monitor PHMC's performance. The contractor will submit a weekly status report on its activities to OHCF. Contact: Athas H. Tsigas, Region III, FTS 596-1323.

EPSDT

EPSDT SCREENS IN TEXAS SCHOOLS

The Dallas Independent School District (DISD) and the San Antonio Independent School District (SAISD) recently were certified Medicaid providers for providing EPSDT screens. Both school districts began screening EPSDT eligibles in February.

DISD is providing screens in one education center containing kindergarten through twelfth grades. SAISD is providing screens in 90 schools throughout the San Antonio area. Both schools have provided education to parents and children through films, slides, newsletters, etc., about the need for preventive health care, the EPSDT program, and the availability of EPSDT screens through the schools. Nurses will perform the screens under the supervision of a pediatrician.

The projects are being conducted on a pilot basis through May 1982. At that time, the projects will be evaluated to determine if they should continue. These projects are the result of many hours of hard work, planning, and coordination by the staff of the school districts, the Texas Department of Human Resources, and the Texas Education Agency. Contact: Betty Collins, Region VI, FTS 729-6481.

MMMI EVENTS

State Medicaid Group Meeting
July 15 Baltimore, MD

Contact: Edward Palder
301-594-8940
FTS 934-8940

MQC Error Rate Regression
Formula Workshop
August 11-12 Baltimore, MD

Contact: Joyce Sutton Zutell
301-594-8945
FTS 934-8945

Carrier Representative Group
(CRG) Meeting
September 18 Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

Fiscal Intermediary Group
(FIG) Meeting
Sept. or Oct. Balto., MD
(To be Announced)

Contact: Paul Beller
301-594-9455
FTS 934-9455

State Medicaid Directors'
Mid-Year Conference
December 3-4 New Orleans, LA

Contact: Edward Palder
301-594-8940
FTS 934-8940

WATCH THIS SPACE FOR ANNOUNCEMENTS
OF ADDITIONAL PROGRAMS

MEDICAID TRANSPORTATION VALIDATION REVIEW

TRANX, STRPO, RNDTRP 1, RNDTRP 2, PROCE 9, are the names of computer listings from five Cobol programs, developed by the Office of Systems Analysis and Region I, to run against State Medicaid historical payment files. These programs helped to facilitate program validation review of Medicaid transportation payment in one of the larger New England States. In addition, the programs refine available data to aid in the selection process of vendor transactions. Region I's Office of Program Integrity is currently completing the review. Findings will be presented at a later date.

The first program, TRANX, extracts all 1979 Medicaid payments involving transportation vendors (in and out of State) from the historical payment files. This creates a reduced file of approximately 268,000 records for processing.

The second program, PROCE 9, selects and prints a statistical sample of claims where the billed procedure code matched one of nine identified for high utilization. The program supplies complete summary statistics of all transactions for projecting results of audit findings, even though the program prints only ten percent of the claims that match the criteria.

During the survey phase of the review, certain provider types and provider payment arrangements appeared to be more suspect than others. After identifying four such providers, the third program, STRPRO, was developed to produce a stratified printout for each provider in descending dates of service for selection purposes.

A report by the Office of the Inspector General of Medicaid transportation services in Region V identified problems involving ambulance providers that billed for both one way and round trip services for the same patients on the same dates of service. As a result, the fourth program, RNDTRP 1, was designed to produce a printout of one way and round trip non-emergency ambulance transactions billed for the same recipient on the same date of service, summarized by provider.

The last similar program, RNDTRP 2, was developed to identify chair-care providers that met the above criteria. For additional information contact Alex Reveliotty, Office of Program Integrity, Region I, FTS 223-4437.

HEALTH SERVICES ADMINISTRATION DIRECTORY

The Association of University Programs in Health Administration (AUPHA), a consortium of faculty from 123 colleges and universities, recently published a revised directory of baccalaureate and master's level programs. The 276 page directory includes a comprehensive list of undergraduate and graduate health administration programs, their directors and faculty; admission requirements; application/acceptance timetables; curriculum, cost and student aide information; enrollment and accreditation data; and a list of international programs. This directory also lists programs dedicated to the advancement of administrative technology and the preparation of qualified administrative leadership for health services.

The directory may be ordered from AUPHA, One Dupont Circle - Suite 420, Washington, DC 20036. Cost, including postage, is $7.50 for pre-paid orders and $8.25 with a purchase order.

WISCONSIN'S SURGICAL SECOND OPINION PROGRAM

The State of Wisconsin began a mandatory surgical second opinion program (SSOP) February 1, 1981. The program applies to Medicaid payments for ten elective surgical procedures.

Except in cases of emergent or urgent surgery, these procedures will require a second opinion: cataract extraction, cholecystectomy, certain D&C procedures, hemorrhoidectomy, inguinal hernia repair, hysterectomy, hip or knee joint replacement, tonsillectomy and/or adenoidectomy, transurethral resection - prostate, and varicose vein surgery. Under the State's program, any circumstance in which delay of treatment may cause death or permanent impairment of a recipient's health is considered an emergency. An acute condition, less serious than an emergency, which necessitates hospitalization is defined as urgent. In these cases the surgeon must label the claims as such and attach a copy of the hospital discharge summary.

Wisconsin's Department of Health and Social Services SSOP mechanism will work as follows:

1. The physician informs the recipient of SSOP.

2. The recipient's primary care physician or surgeon will submit to the State Medicaid Agency a second opinion request form, if the procedure is one of the ten listed.

3. The State staff will contact the recipient and a second opinion physician to arrange a second examination. (Wisconsin Physician Services, Inc., the voluntary second opinion program listholder, gave the State a list of physicians willing to provide second opinions.) The recipient's background information is sent to the second opinion physician.

4. After the second examination, the second opinion physician informs the recipient and the State agency of his/her opinion. The second opinion physician cannot receive Medicaid reimbursement if he/she performs the surgery.

5. The State informs the first physician of the second opinion, and that the surgical procedure will be paid for within the next six months if the recipient requests it. The second opinion need not be confirmatory in order to obtain approval for the proposed surgery.

6. The recipient tells the first physician of his/her decision to proceed or not proceed with the surgery.

The State anticipates that some 5,000 requests for second opinions will be filed in one year. It is hoped that second opinions will save $400,000 the first year (by not confirming the first opinion), along with the SSOP acting as a deterrent to physician's recommendations for surgery. Experience to date has shown that only ten percent of the first physician's opinions are not confirmed.

A staff of three is currently handling the heavy volume of paper work for this program which will terminate on June 30, 1982, unless the State legislature authorizes its continuation. An evaluation report is due to the legislature in January 1982. Contact Gerald Spatz, Region V, FTS 353-4363.

NOTES from the Office of Intergovernmental Affairs

On March 23, Dr. Carolyne K. Davis, HCFA Administrator, announced the appointment of James Scott as the new Director of the Office of Intergovernmental Affairs. Formerly, Mr. Scott was Vice President of the Kansas Hospital Association, and taught Hospital Financial Management at his alma mater, Kansas State University.

Mr. Scott will spend most of his time in OIA's Washington office. Dr. Davis has asked him to maintain close contact with both the National Governors' Association and the American Public Welfare Association. He recently told his staff, "This is certainly a challenging time to be working in the area of intergovernmental relations. We see unfolding a new philosophy relating to State flexibility and latitude in dealing with their Medicaid programs. We might see a dramatically revised approach to the Federal role in terms of monitoring State activities."

Before Mr. Scott took office on May 4, he was able to spend two days away from his previous job to attend the State Medicaid Directors' Conference in Philadelphia, where he met many State directors on an informal basis. Mr. Scott succeeds Richard Heim who resigned as Director, OIA in February. Mr. Scott's telephone number is 202-426-8390.

JOINT STATE/FEDERAL TPL PROJECT

The State of Washington's Third Party Liability program saved $10.8 million on over 113,000 claims in calendar year 1980, by identifying and using other medical resources available to recipients. However, preliminary findings of a joint State/Federal project suggest that third party liability resources are not being fully utilized there.

A sample review of 366 cases from King County's universe of 20,000, revealed third party liability in 25.4 percent (93 cases). Of the 93 TPL cases, 26 were already known to Washington State (27.9 percent), and 67 were new cases identified by the project (72.1 percent).

Recovery efforts have begun on all sample TPL cases not pursued previously. To date, $3,433.78 has been recovered from seven liable third party cases. Additional claims on these cases are still pending as are claims on an additional 51 cases. Thirty-five cases contained no recoverable claims either because: the State was already recovering, deductibles were not met, services were not covered, HMO coverage was provided by the State, or there were simply no claims paid by Medicaid.

Although the project findings are still incomplete, an interim report describing the identification and recovery procedures used in the project, has been prepared. The final report with more complete data will be available in the Fall. Copies of the report and further information on the project are available through the following contacts: State of Washington - Dan Dowler, 206-753-2465, FTS 753-2465; Region X - Dan Dolan, 206-442-1070, Steve Moses, 206-442-1382, and Dave Vedder, 206-442-0506.

ACTION TRANSMITTALS

These Action Transmittals have been issued by HCFA between February and May.

AT-81-12 Title XIX, Social Security Act: Requirements Applicable to Sterilizations (Hysterectomies) (Refer to 42 CFR Part 441)

AT-81-13 Title XIX, Social Security Act: Section 1903(g) - Utilization Control (UC) Validation Survey for the Quarter Ending December 31, 1980, in All Participating State Agencies (Refer to Sections 1902(a)(26) and (31) and 1903(g)(1)(D) of the Social Security Act; 42 CFR 456.655(a))

AT-81-14 Title XIX, Social Security Act: Entitlement of Individuals Receiving Cash Assistance Under the Foster Care Maintenance Payments Program or the Adoption Assistance Program (Refer to 42 CFR Parts 431, 435 and 436)

AT-81-15 Implementation of Section 962 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499)

AT-81-16 Title XIX, Social Security Act: Federal Financial Participation (FFP) for Abortions as a Family Planning Service with Instructions for Preparation of the Quarterly Report of Abortions (Form HCFA 64.9b) for the Medical Assistance Program (Refer to Sections 1903(a)(5) and 1905(a)(4)(C) of the Social Security Act)

AT-81-17 Title XIX, Social Security Act: Discontinuance of Action Transmittals to Transmit Regulatory Documents

AT-81-18 Further Instructions Regarding EPSDT Monthly Lists (Refer to 42 CFR 441.90)

AT-81-19 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated, or Where Effectuated Sanction was Withdrawn (Refer to Sections 506(f)(2), 1862(d), 1160, 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-81-20 Title XIX, Social Security Act: Protection of Patients' Funds - CORRECTION (Refer to HCFA-AT-80-61, August 1980, and HCFA AT-80-62, August 1980)

AT-81-21 Reporting Requirements Imposed Upon State Agencies by Action Transmittals AT-78-4 and AT-79-97 (Refer to 42 CFR 431.800(b), 433.140)

AT-81-22 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated, or Where Effectuated Sanction was Withdrawn (Refer to Sections 506(f)(2), 1862(d), 1160, 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

Action Transmittals - continued

AT-81-23 Sample Cooperative Agreement Between the Medicaid and Title IV-D Agencies (Refer to 42 CFR Part 433.135, HCFA-AT-80-6 dated February 11, 1980)

AT-81-24 Draft Report on Provider Participation in the Medicaid Program

Personnel

MEDICAID

New Single State Agency Directors

Timothy L. Carden - New Jersey Department of Human Services
Acel R. Martelle - Nevada Department of Human Resources

New Medical Assistance Unit Directors

Betsy A. Skloot - Illinois Department of Public Aid
Robert K. Pendergrass, M.D. - Texas Department of Human Resources
Keith W. MacDonald - Nevada Department of Human Resources
Alicia S. Jacobs - Florida Department of Health and Rehabilitative Services
Gwendolyn G. Power - South Carolina Department of Social Services

MEDICARE

Eugene Aune - President, Texas Blue Shield, Group Medical and Surgical Service

Intermediary/Carrier Directory Update

Part V - Medicare Part B Claims Addresses
South Dakota - Claims should be addressed to:

Medicare
Blue Shield of North Dakota
4510 13th Avenue, SW
Fargo, North Dakota 58121

HCFA

Dr. Paul R. Willging, Ph.D. - HCFA Deputy Administrator
John Spiegel - Acting Executive Secretariat, Office of Executive Operations
Harvey Brook - Acting Director, Office of Field Operations
Patrice Feinstein - Director, Office of Legislation and Policy
James Scott - Director, Office of Intergovernmental Affairs

CAPITALIZING STATE RESOURCES

M/MMI's Corrective Action Projects Division (CAPD) provides technical assistance and professional consultative services to Medicaid State agencies. CAPD focuses its efforts on resolving problems which contribute significantly to Medicaid quality control errors. Through CAPD, States are afforded the expertise needed to implement operational improvements in their programs in third party liability (TPL), data exchange, and error prone profiling/eligibility management.

COST CONTAINMENT CATALOGUE

CAPD, in conjunction with the National Governors' Association and the Intergovernmental Health Policy Project, is compiling and catagorizing information on cost containment practices and activities which are underway or being planned in the States. The catalogue will describe State specific cost reduction activity, document program costs/savings associated with the activity, and identify State contact persons who can provide additional information and assistance in regard to each activity.

To date, the joint team has reviewed data gathered from the Commerce Clearinghouse Quarterly and State Medicaid Plans, and has submitted a draft of the catalogue to appropriate State officials for review and comment. Upon finalization of the catalogue, the Exchange will publish information concerning its distribution process and schedule for up-date reprinting. Contact: Arthur Pergam, CAPD Director, 301-594-8942, FTS 934-8942.

CAPD activities continue on the next page.

TITLE XIX/TITLE IV-D PROJECT

CAPD is currently identifying States which may be interested in receiving technical assistance in the Medicaid/ Title IV-D program area. The Division's assistance is focused on facilitating the implementation of the new TPL regulations (42 CFR Parts 433, 435, and 436). These regulations allow States to require assignment of rights to medical support as a condition of eligibility, and allow the Medicaid and Title IV-D agencies to enter into cooperative agreements to enforce medical support from absent parents. Specifically, CAPD Title IV-D technical assistance includes:

- Conducting a Medicaid/Title IV-D cost analysis study to determine the administrative costs and potential savings associated with implementing a cooperative agreement between the Medicaid and Title IV-D agencies.
- Developing and implementing a cooperative agreement that allows an agency to exchange health insurance information and/or pursue dollar recoveries, if health insurance coverage exists.
- Designing and developing forms and procedures to process the data exchanged as a result of the cooperative agreement.
- Developing and mailing health insurance questionnaires to absent parents listed in the States'Title IV-D files to identify Medicaid recipients who have third party insurance coverage.

The new TPL regulations recognize that absent parents have insurance coverage for their Medicaid-eligible children. This represents a significant source of third party liability, to date virtually untapped by State Medicaid agencies. This results from health insurance information not being readily accessible to Medicaid through the custodial parent (Medicaid applicant). The Title IV-D agency routinely collects this information from the absent parent; however, little exchange of data occurs between Title IV-D and Medicaid. Through cooperative activity between these agencies, States have the opportunity to realize significant program savings.

If these Medicaid/Title IV-D services can be of benefit to your agency, or for additional information concerning CAPD Title IV-D services, contact Jane Herlocker at 301-594-9680, FTS 934-9680.

HCFA's NEW MAILING ADDRESS

Beginning July 1, 1981, HCFA's central office mail should be addressed to:

6325 Security Boulevard
Baltimore, MD 21207

Please note this change!

Trainers...Take Note!

The American Public Welfare Association (APWA) announced their 1981 management development training course schedule recently. APWA holds a contract, awarded by the Office of Family Assistance, Social Security Administration, to provide training to State and local executives and middle managers of Aid to Families with Dependent Children (AFDC) and related programs.

As we go to press, the following program openings are still available: two executive training sessions, August 16-21, Sacramento, California, and September 14-18, Lansing, Michigan; and two advanced seminars scheduled for September 27 - October 2 in Austin, Texas, and Athens, Georgia. The advanced seminars are open to anyone, including those who take executive training.

Course titles are:

Executive Development Training:

Agency Leadership: Can Anybody Do the Job?; How to Maintain Organizational Capacity and Control; Financial Management During the Austere '80s; Constituency Building: The Art of Turning on the Power Brokers

Advanced Seminars:

How to Build Constituencies To Mobilize New Resources; How to Use Your AFDC Management System to Enhance Management Effectiveness; Male and Female Managers Working Together in a Multiracial/Multicultural Environment; The Art of Effective Employee/Labor Relations in Human Service Management.

Applicants should channel their requests through their agency director for approval. For more information, write Jerry Hissong, Center for Studies in Human Services, APWA, 1125 Fifteenth Street, NW, Washington, DC 20005.

COMMON CLAIM FORM STATUS

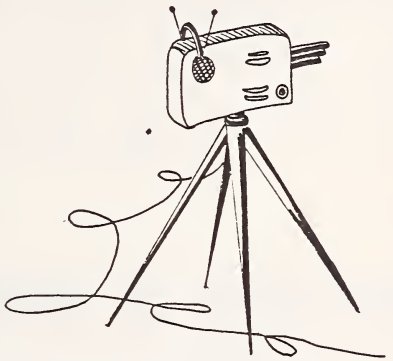
Since February 1980, HCFA has been encouraging States to adopt its Common Health Insurance Claim Form (HCFA-1500) for services provided by physicians and suppliers. Currently, 17 States have agreements between Medicare carriers and other third party payors for local production and distribution of the form. Parties to these agreements have been using the form or will convert to the form by June 30, 1981. In 16 of these States, the Medicaid programs have joined the other payors in planning the form's use.

In 13 States and the District of Columbia, agreements among the third party payors are anticipated, with conversion to the common form by the end of 1981. Twelve of these agreements may include State Medicaid programs.

In 19 States and Puerto Rico, the Medicare carriers will begin using the HCFA-1500 without agreements with other local third party payors. In all of these States, except three, conversion to the new form will be completed by June 30, 1981. For more details, telephone Reynold Sawatzky, 301-594-9504, FTS 934-9504.

MORE NOTES FOR TRAINERS

Medicare/Medicaid, Which is Which? has recently been distributed both in 3/4" videocassette and 16mm film to HCFA regional offices, Medicare contractors, and Medicaid State agencies. This presentation explains the basic differences and similarities between the two programs. It has been used with great success by and for HCFA's central and regional offices, and Social Security offices. There is a limited number of videocassettes and 16mm films still available for interested organizations not covered by the initial distribution. To obtain copies of the film or tape, call Joseph Boston, M/MMI, 301-594-8648, FTS 934-8648.



INFORMATION MEMORANDUMS

IM-81-05 List of Single State Agency Directors and Medical Assistance Unit Directors

IM-81-06 Title XIX, Social Security Act: The Release of Confidential Information for Administrative Purposes - Definition of Administrative Purposes (Refer to 42 CFR 431.301 and 431.302)

IM-81-07 A Surveillance and Utilization Review Subsystem of MMIS Perspective for the Eighties

IM-81-08 Proposed Revisions to the Medicaid Quality Control (MQC) System

IM-81-09 National Conference on Management Information Systems (MIS) - Benefits to Management, Kansas City, Missouri, June 2-4, 1981 -- INFORMATION

BENEFICIARY SERVICES AWARD

HCFA will again recognize outstanding beneficiary service this year at its annual awards ceremony and is seeking nominations for this award. One cash award will be given to a HCFA employee; certificates of merit will be awarded to other HCFA employees, and to persons from State agencies, non-profit associations, volunteer organizations, or contractors. Both awards recognize individuals who have made major contributions in the area of beneficiary services.

Examples of achievements that would merit these awards are: original development of an improvement in methods or procedures that results in a major benefit to beneficiaries; consistent and superior performance in service to individual beneficiaries; or, development of innovative programs or resource materials that would increase beneficiary access to service or improve their knowledge of HCFA programs.

Any management official or supervisor having direct knowledge of such achievements may initiate the nomination. The nomination should be in memorandum/letter form and include complete identification and address(es) of the nominee(s), a brief description of the contribution or achievement, and a proposed citation of 25 words or less. Nominations must be received by July 24 at this address:

Director, Office of Beneficiary Services
Health Care Financing Administration
Room 2424, Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207
Attention: Beneficiary Services Awards

For further information, call Jillian Richter, 301-594-1659, FTS 934-1659.

HCFA'S REPORT OF BENEFICIARY SERVICES

HCFA's Office of Beneficiary Services has issued a report on beneficiary service activities provided by HCFA regional offices, Medicaid State agencies, and Medicare carriers and intermediaries. The publication is based on information supplied by HCFA regional offices, describing the nature and extent of these activities. It also includes individual assessments by HCFA regional offices, and an overall assessment of types of services provided to Medicare and Medicaid beneficiaries in Social Security district offices within each region.

This report, Services to Medicare and Medicaid Beneficiaries, is available through the Office of Beneficiary Services. Contact Pat Douglass, 301-597-2272, FTS 987-2272, or write to HCFA, Office of Beneficiary Services, 1-C-11 Oak Meadows, 6325 Security Boulevard, Baltimore, Maryland 21207.

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CLEARINGHOUSE

Legislative Ledger

On March 17, Senator William Proxmire presented S.718 to the Committee on Finance, amending Title IV of the Social Security Act. Under this bill, States must require recipients of Aid to Families with Dependent Children (AFDC) to participate in community work programs if able to do so.

Senator David Boren introduced an additional amendment to Title IV of the Social Security Act (S.660) to the Committee on Finance, March 10. This Bill includes a demonstration program of block grants to States in lieu of Federal matching funds for the AFDC program.

For further information on these or other HCFA legislative issues, call Richard Chambers, HCFA's Legislative Reference Office, 202-426-3717.

ADMINISTRATIVE SANCTIONS

Since Medicare and Medicaid began to apply administrative sanctions against providers in 1976, 184 such sanctions have been effected. Out of 91 sanctions imposed during FY 80, 72 were against practitioners and providers suspended or excluded based on criminal convictions, and 19 were based on administrative or medical abuse of the Medicaid or Medicare programs.

Because FY 80 was the first full year the suspension process was in effect, a larger amount of administrative sanctions were documented. This was a result of suspensions mandated for physicians/practitioners convicted of Medicaid/Medicare offenses, the increase in the number of Medicaid convictions, and the dramatic rise in sanctions imposed without a conviction for both programs.

During FY 80, the authority to administratively sanction a health care provider was delegated from the HCFA Administrator to the Bureau of Quality Control (BQC) Director. This redelegation of authority enabled the Office of Program Validation and BQC to process most determinations within 30 days. Previously, administrative sanctions could take up to six to twelve months to be processed. Contact: Linda Rudolph, 301-597-2674, FTS 987-2674.

REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact persons listed with each regulation.

Medicaid and Medicare Programs: Schedules of Guidelines for Physical Therapy and Respiratory Therapy Services - Final Notice
02/25/81 Federal Register
Contact: William Goeller, 301-597-1802, FTS 987-1802

Medicare Program: Supplemental Health Insurance Panel; Meeting - Notice
03/04/81 Federal Register
Contact: Robert Silva, 301-594-9412, FTS 934-9412

Medicare Program: Solicitation of Comments for Consideration in a Study of Methods for Providing Coverage for Orthopedic Shoes - General Notice
03/09/81 Federal Register
Contact: Mildred Corbin, 301-597-1457, FTS 987-1457

Medicaid and Medicare Programs: Pharmaceutical Reimbursement Board; Suspension of Maximum Allowable Cost Limits on Specific Drug Products - Suspension of Maximum Allowable Cost Limit on Griseofulvin, Microcrystalline, Oral Tablets, 500 mg.- Notice
03/12/81 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

Medicaid and Medicare Programs: Pharmaceutical Reimbursement Board; Suspension of Maximum Allowable Cost Limits on Specific Drug Products - Suspension of Maximum Allowable Cost Limits on Methenamine Hippurate, Oral Tablets, 1 gram; Fluocinolone Acetonide, Topical Solution, 0.01%; Fluocinolone Acetonide, Topical Cream, 0.01%; and Fluocinolone Acetonide, Topical Cream, 0.025% - Notice
03/12/81 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

Medicaid and Medicare Programs: Privacy Act of 1974; New and Altered Systems of Records - Waiver of Advance Notice Period for a New System of Records and an Altered System of Records
03/24/81 Federal Register
Contact: Alan Friedlob, 301-597-2364, FTS 987-2364

Medicaid and Medicare Programs: Pharmaceutical Reimbursement Board; Proposed Maximum Allowable Cost (MAC) Limits and Announcement of Public Hearing - Notice
03/31/81 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

REVIEW

MEDICARE CONSULTATIVE ACTIVITIES

FISCAL INTERMEDIARY GROUP MEETING

The March 12 Fiscal Intermediary Group (FIG) meeting focused on four staff papers detailing *major* FIG concerns. The staff papers covered: Need to Improve HCFA Coordination Between Bureaus and Regional Offices; End-Stage Renal Disease (ESRD) Issues; Performance Standards and Criteria Issues; and, Status of FIG Open Items.

Another agenda item generating considerable interest and concern was the status of the FY 81 budget and FY 82 budget outlook. The severe budgetary restraints were also reviewed. FIG requested that a number of program initiatives be eliminated or deferred in order to reduce contractor administrative costs.

MEDICARE CONTRACTORS' CONFERENCE

HCFA and the Medicare contractors have jointly decided to cancel the Medicare Contractors' Conference scheduled for September 1-2, due to severe budgetary constraints. The next CRG meeting will be held in Baltimore, on September 18, 1981. Still unscheduled is the next FIG meeting.

For further information, contact Paul Beller, 301-594-9455, FTS 934-9455.

MEDICARE OFFICE HONORED

Connecticut General's Medicare office in Wallingford, Connecticut, recently received that company's Superior Achievement Award for 1980. During that year, the Wallingford office implemented and updated a more sophisticated system without interruption to its claims processing and service to beneficiaries. More than 2 1/4 million claims were processed by a staff of 219 people at a unit cost of $2.39.

The Wallington Office was one of just five Connecticut General field offices so honored. Connecticut General has 50 field offices across the country. This company award is normally given in recognition of outstanding accomplishment in sales or cost savings; the Medicare field office cannot claim this kind of benefit for the company, thus recognition of its performance is particularly noteworthy.

"This was the first time, to my knowledge, that a field office received this recognition," remarked Stanton Collins, Jr., Boston's Regional Medicare Director.

Department of Health and Human Services
Richard S. Schweiker, Secretary

Health Care Financing Administration
Carolyne K. Davis, Ph.D., Administrator

Bureau of Program Operations
Tera S. Younger, Acting Director

Medicaid/Medicare Management Institute
Doris Z. Soderberg, Director

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301-594-8699
FTS-934-8699

LONG TERM CARE DISCUSSION PAPER

HCFA's discussion paper on long term care is now available. The paper, "Long Term Care: Background and Future Directions," covers: the need for long term care among the elderly and physically disabled, the services and settings used by this population under Federal programs, the problems of the current service delivery system in meeting their needs, and the broad financing options for reform. In addition, one chapter presents a summary of research questions frequently asked concerning the expansion of noninstitutional services.

Copies of this paper are available, as the supply lasts, from: Edward Neuschler, Director, Division of Medicaid and Long Term Care Policy, Office of Policy Analysis, HCFA, Room 325H, Humphrey Bldg., 200 Independence Ave., SW, Washington, DC 20201. Comments and reactions are encouraged.

CORRECTION

The article, Medicare Premium Billing and Collection Functions Centralized, on pages 6-7 of the March 1981 MMX has an error of omission. The sentence, "About 825,000 Medicare beneficiaries are billed directly for premiums at a cost of about $103 million yearly." should read, "About 825,000 Medicare beneficaries are billed directly for premiums at a cost of about $1.5 million; HCFA collects about $103 million yearly. We are happy to set the record straight for our authors. Questions or comments can be directed to Castomal Alexander, 301-594-9882, FTS 934-9882.

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